SBCH Cost Report Instructions 2015

Direct Medical & Administrative Cost Claiming Guide for the State of CT Department of Social Services Medicaid School Based Child Health Program

For school year
July 1, 2014 –
June 30, 2015

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Overview

The State of Connecticut Department of Social Services (the department), the single State agency administering the Connecticut Medical Assistance Program, calculates payment rates for services covered under the Medicaid School Based Child Health (SBCH) program.

The department follows OMB Circular A-87 in developing school district specific fee-for-service rates for services covered under the SBCH Program. Rates for services are based on the Medicaid allowed costs applicable to the services covered under the SBCH program. In addition to direct services, each school district participating in the SBCH program is allowed to claim administrative costs allocated to the administration of the SBCH program.

Beginning October 1, 2010 and forward, the rate methodology approved by CMS reflects the certified public expenditure model. This model requires the department to annually reconcile and settle any differences between the interim payments issued to districts and the actual costs incurred by districts to provide SBCH program covered services to Medicaid covered students enrolled pursuant to students' Individualized Education Program (IEP). Fee-for-services SBCH Program rates are reviewed annually and calculated after the cost reconciliation and settlement process is finalized.

Each participating school district that received SBCH program payments for services, with dates of service falling during the reporting school year, is required to complete the SBCH Cost Report. The SBCH cost report provides detail of the Medicaid allowable costs incurred by the district to deliver and administer the SBCH program. The cost report is completed by all districts who submitted Medicaid claims for services under the SBCH program with dates of service falling within the cost reporting period. Districts failing to complete a cost report will be required to refund any interim payments received.

General Information

Filing Deadline

Cost reports must be completed within 12 months of the close of the state fiscal year (June 30th). DSS will determine a reasonable deadline within this time frame to allow for completion of the Cost Report. This deadline is firm regardless of holidays and weekends. Exceptions to the deadline will be granted only for extreme extraordinary circumstances. In these instances, the provider must inform DSS in writing of the circumstance at least 10 days prior to the submission deadline. **The 2014-2015 school year cost report is due by November 30, 2016.**

The school district superintendent must certify costs annually using the Certification Statement included in the template provided.

Original certification forms must be printed on school district letterhead, signed, and submitted to the following address. Faxed or emailed copies **will not** be accepted. Certification forms are required to be completed prior to the submission of the cost report for DSS review.

State of Connecticut-DSS
SBCH Program – 9th Floor
Attn: CON and Rate Setting
55 Farmington Avenue
Hartford, CT 06105-3725

Confirmation of receipt by DSS will be provided by email correspondence.

Direct Service Interim Claims

Interim Claims must be submitted within one year from the date services were provided to comply with timely filing guidelines. Districts are encouraged to submit interim claims at least quarterly to avoid possible missed claim submissions. All Medicaid covered services provided to eligible students by qualified program providers whose costs are included on the cost report must be documented as required by Medicaid, Connecticut state statute, and program record retention policies.

Administrative Personnel Costs

Salary and fringe benefit expenditures for eligible staff may be included as administrative personnel costs. Eligible staff is defined as follows: Personnel who were included in the RMTS participant pool during the reporting school year.

Cost Pool Components and Cost Allocation

Direct Services Costs include:

- Salaries and Wages
- Fringe Benefits
- Cost of Purchased Services
- Cost of Supplies and Materials
- Cost Purchased Property Services
- All Other Allowable Costs
- Indirect Costs

These costs must be consistent with OMB Circular A-87 and should reconcile to expenditures reported to the State Department of Education on the ED001 Report. Salaries and Wages and Fringe Benefits costs claimed should only be for the direct services providers and Medicaid Billing personnel included in the quarterly RMTS participant pool submitted through the RMTS system. Cost of Supplies and Materials used by the direct services providers and Medicaid billing personnel, cost of Purchased Property Services essential for the delivery of services and essential for Medicaid billing, and All Other Allowable Costs identified with Direct Services are reimbursable costs.

Administrative Costs includes:

- Salaries and Wages
- Fringe Benefits
- Purchased Services
- Transportation
- Depreciation or use allowance for equipment
- Depreciation or use allowance for buildings and improvements

These costs must be consistent with OMB Circular A-87 and include Salaries and Wages and Fringe Benefits of administrative support staff, Purchased Services of administrative support staff (if any), Transportation of special education students when transportation services are prescribed in the student's IEP, equipment depreciation or use allowance of 6 1/3% per year, and buildings and improvements depreciation or use allowance of 2% per year.

Indirect Costs are calculated by applying 10% de Minimis rate to direct costs or, if a district submitted a request to the State Department of Education for an Authorized Indirect Cost Rate, apply to direct costs the approved unrestricted rate.

Note: Districts indicating an Authorized Indirect Cost Rate must submit a copy of the letter provided by the State Department of Education indicating the rate with the dates of authorization for the rate to be used. Failure to provide supporting documentation will result in system default to the 10% de Minimis rate. This letter must accompany your submitted cost report as a PDF attachment.

Cost Allocation Bases

Cost Allocation Bases are either an average of the quarterly employee Random Moment Time Studies or an average of the quarterly student enrollment statistics. Two types of cost allocation bases are utilized to calculate the Medicaid allowable cost application to the SBCH program:

1. **Statewide Allocation Base**: based on RMTS and used to allocate the following costs:
    - Salaries and wages and fringe benefits of the direct service providers, Medicaid billing personnel and Medicaid administrative support staff;
    - Other expenses of the direct services providers, Medicaid billing personnel, and Medicaid administrative support staff; and
    - Medicaid Administrative Staff Support Costs.

2. **District Specific Allocation Base**: based on student enrollment statistics and is used to allocate the following costs:
    - Transportation Costs; and
    - Depreciation and Use Allowance Costs

3. The **district-specific Medicaid Penetration Rate (IEP Rate)** is based on student enrollment and is applied to determine the Medicaid allowable direct services costs.

4. The **district-specific Medicaid Eligibility Percentage (MEP Ratio)** is based on Medicaid eligible district students and is applied to determine the Medicaid allowable administrative costs.

5. **"Statistical Data"** information is gathered by districts using the new Medicaid verification system for the first school day of the quarter and submitted to DSS for recording. In SFY 2016, DSS received authorization from CMS (Centers for Medicare & Medicaid) to obtain Medicaid ratios for the CT SBCH program on an annual basis. The cost report template will automatically calculate the percentages of students in each eligibility category based upon the statistical data provided by the district.

    Note: The records of all Medicaid eligible students with parental consent counted in the eligibility statistics are subject to audit.

Statistics Type of data tables

Type of Data	Description of the Type of Data
Total District Students	Number of all students enrolled in the LEA, including those attending out of district schools where the LEA is financially responsible for the student.
Total District Medicaid Students	Number of students who are Medicaid eligible in the LEA regardless of whether parental consent has been obtained, including those attending out of district schools, where the LEA is financially responsible for the student.
Total Students with Medical* Services included in IEPs	Number of all students who are enrolled in the LEA, including those attending out of district schools where the LEA is financially responsible for the student, that have at least one SBCH covered direct service included in their IEP.
Total Medicaid Students receiving Medical Services per their IEP and for whom Parental Consent is on file	Number of Medicaid eligible students who are enrolled in the LEA, including those attending out of district schools where the LEA is financially responsible for the student, who have at least one SBCH covered direct service included in their IEP and for whom the district has Parental Consent on file and for whom the district seeks Medicaid reimbursement.
Total SpEd Students with Transportation	Number of SpEd students enrolled in the LEA, including those attending out of district schools where the LEA is financially responsible for the student, who have at least one SBCH covered direct service included in their IEP that are provided specialized transportation.
Total Medicaid SpEd Students with Transportation listed in the IEP	Number of Medicaid eligible SpEd students enrolled in the LEA, including those attending out of district schools where the LEA is financially responsible for the student, who have at least one SBCH covered direct service included in their IEP and for whom the district has Parental Consent on file that are provided specialized transportation.

**Medical necessary services may include the following: audiology services, behavioral health services (psychological and counseling services), behavior modification services (applied behavior analysis), clinical diagnostic laboratory services, medical services provided by licensed physicians, physician assistants or nurse practitioners, nursing services, occupational therapy services, optometric services, personal care services, physical therapy services, respiratory care services, and speech/language services.*

Record Retention Policy

School districts filing Medicaid claims under the SBCH program must retain documentation in support of these claims, based upon federal requirements, for at least 6 years in the event of an audit by either state or federal authorities.

For example, records pertaining to the 2015 claims for dates of service between 10/01/2014 and 6/30/2015 shall be retained until June 30, 2026.

Examples of records / documentation to be retained include but are not limited to:

1. Medical provider qualifications associated with licensing and certification
2. Payroll records associated with school personnel providing services
3. Copies of contracts with medical providers
4. Cost report and Time study source documents
5. Copies of any manuals related to the time study, cost allocation plan, or procedures related to the Medicaid School Based Child Health reimbursement

Technical Requirements

The SBCH cost report was developed as a Microsoft Excel (version 2010) workbook. All cost report files must be submitted electronically via email to the department to the DSS SBCH mailbox at **DSS.SBCH@ct.gov**. Paper copies are not permitted and are not required in addition to the electronic file. PDF versions of the cost report are not accepted. Email confirmation will be returned for received files.

Template Information

The template provided is submitted with the following name: ***SB#xxx_Name_SBCH_2015 Cost Report _template.*** The template should be saved to the preparer's computer updating the file name as shown in the following example: for East Granby school district, the cost report would be named: **SB#040_East Granby_SBCH_2015 Cost Report_working.** Naming the district file properly will ensure accurate receipt by DSS. Town code information may be found within the workbook on the tab labeled "1a State Town Codes".

- Tabs colored in **blue** are informational in relation to the various tabs within the workbook;
- Tabs colored **green** require entry/completion by the district;
- Tabs which are not colored are auto-filled by completing the green tabs within the workbook;
- Formulas/calculation areas have been password protected;.
- Please do not add additional columns or calculations to any of the worksheets within the Template
- All monetary entries will automatically format to whole dollars with a dollar sign.

The following tabs are included in the cost report template. Those in bold require completion by the district:

A	Title Page
B	List of Forms
C	SBCH Approved Services
D	State Town Codes
E	SBCH Chart of Exp Codes
F	Position Codes & Titles
1	**Certification Statement**
1a	Certification
1b	**Provider Data**
2	Medicaid allocation %
2a	**Medicaid allocation % detail**
3	**ED001, Sch #4 expenses**
4	DSP Time Study Summary
5	Admin Time Study Summary
6	Wkst #2 Direct S&W
7	Wkst #2a Admin S&W
8	**Wkst #3-404(Purch Prof Serv)**
9	**Wkst #4-407(Suppl & Material)**
10	**Wkst #5-40(Purch Prop Serv)**
11	**Wkst #7 Transportation**
11a	CAP Specialized Transportation
11b	Specialized Transp Cost
11c	DW client count w paid serv
11d	Client count serv+transp
11e	**Federal Payments**
12	**Wkst #8 Depreciation allowance**
13	**Wkst #9-411(All Other Exp)**
14	**Register(10)Social Worker**
14	**Register(20)Audiologist**
14	**Register(22)Hear-Instr-Spec**
14	**Register(30)Psychologist**
14	**Register(31)MFT**
14	**Register(40)Resptry Therpst**
14	**Register(50)PT**
14	**Register(51)PT Assist**
14	**Register(60)SL**
14	**Register(70)Nurse-APRN**
14	**Register(71)Nurse-RN**
14	**Register(72)Nurse-LPN**
14	**Register(80)Counselor**
14	**Register(90)OT**
14	**Register(91)COTA**
14	**Register(100-104)Medical MD**
14	**Register(105)Psychiatrist**
14	**Register(800)Billing**
14	**Register(900)Audiometrist**
15	**Register-Admin S&W, FB**
16	**Register-Transport S&W, FB**

Many of the blank pages included in prior versions of the cost report have been removed and new tabs or pages have been added causing a change in many of the page numbers. **It is important that this guide be used throughout the completion of the cost report.**

Employee listing

Districts are provided with a listing of the employees included in the RMTS participant pool for each of the 3 quarters for which time study was conducted for use in determining who to include on the applicable cost report registers. **The list is included on the very first tab of the Cost Report template named "Employees".** Only the employees included on this list may be included in the cost report. Employees are listed in order of position code and last name. For employees who were terminated (or left) the district during the school year, the effective date of termination is listed next to the last name. Employee listings are provided in pdf format to prevent editing (adding or removing employees). Employee salaries that are included should be relevant to the number of quarters for which they were available for participation in the RMTS. For example:

- If employee A was included in the RMTS participant pool for Q2, Q3, and Q4 their entire salary and fringe benefit amount should be listed on the register;

- If employee A was included in the RMTS participant pool for Q2 and Q3 but not quarter 4 (or included for a total of 2 out of the 3 quarters), then ¾ of their salary and fringe benefit amount should be listed on the register;

- If employee A was included in the RMTS participant pool for any single quarter, then ½ of their salary and fringe benefit amount should be listed on the register.

- Employees who are on paid medical leave are considered available. For example, if employee B was included in the RMTS participant pool for Q2 but on paid medical leave (or paid extended leave of any kind), that employee may be listed on the register with their entire salary and fringe benefit amounts.

- If employee A was included in the RMTS participant pool for a single quarter but terminated their employment with the district, the salary and fringe paid from the start of the school year until their termination should be listed on the register.

Employee salary and fringe benefit amounts should be listed as those costs which are actually paid during the time frame of the cost report.

Requests for Additional Information (RAI)

Questions pertaining to district submitted cost reports and the information contained within said report will be communicated to the individual submitting the cost report via email in a Request for Additional Information or RAI. DSS will make two attempts to obtain additional information using the RAI process. Failure to complete the requested RAI after the second request by the indicated due date will result in DSS making a determination regarding the costs for application to the cost report.

Supporting Documentation

Districts must submit the following in addition to the required cost report:

- a copy of the complete ED001 submitted to the CT State Department of Education;
- a copy of the districts' letter provided by the CT State Department of Education indicating an Authorized Indirect Cost Rate (if using a rate other than the 10% de minimis rate) indicating the rate with the dates of authorization for the rate to be used.

Audit

All supporting accounting and school records, statistical data and all other records related to the provision of School Based Child Health services paid for by the department shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for the fiscal year by the LEA, the department's payment rate for the said period shall be subject to adjustment.

Questions and Assistance

For questions or assistance, please contact DSS at 860-424-5695. Please be sure you have read through the guide completely so that DSS may better assist you in providing an answer to your question(s).

Completing the Required Worksheets

Page 1b – Provider Data

New fields have been added to this worksheet. The additional information will ensure that DSS is matching the correct cost report the correct district and that the applicable contact information is included for further communication. Please complete all of the shaded areas. Fields on this tab include:

- School District Name
- LEA Number (refer to page D State Town Codes)
- National Provider Identifier (NPI) number
- Address 1 and Address 2
- City, State, and Zip Code
- Superintendent Name
- Finance Director/Business Manager Name
- Finance Director/Business Manager Phone
- Finance Director/Business Manager Email
- Cost Report Preparer Name*
- Cost Report Preparer Email*
- Cost Report Preparer Phone*

*If multiple individuals prepared the cost report, please list all names here with their corresponding email and phone information.

Connecticut Medicaid SBCH **Page 1b**
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

School District Information

School District: 0
LEA Code: 0
Fiscal Year End: June 30, 2015

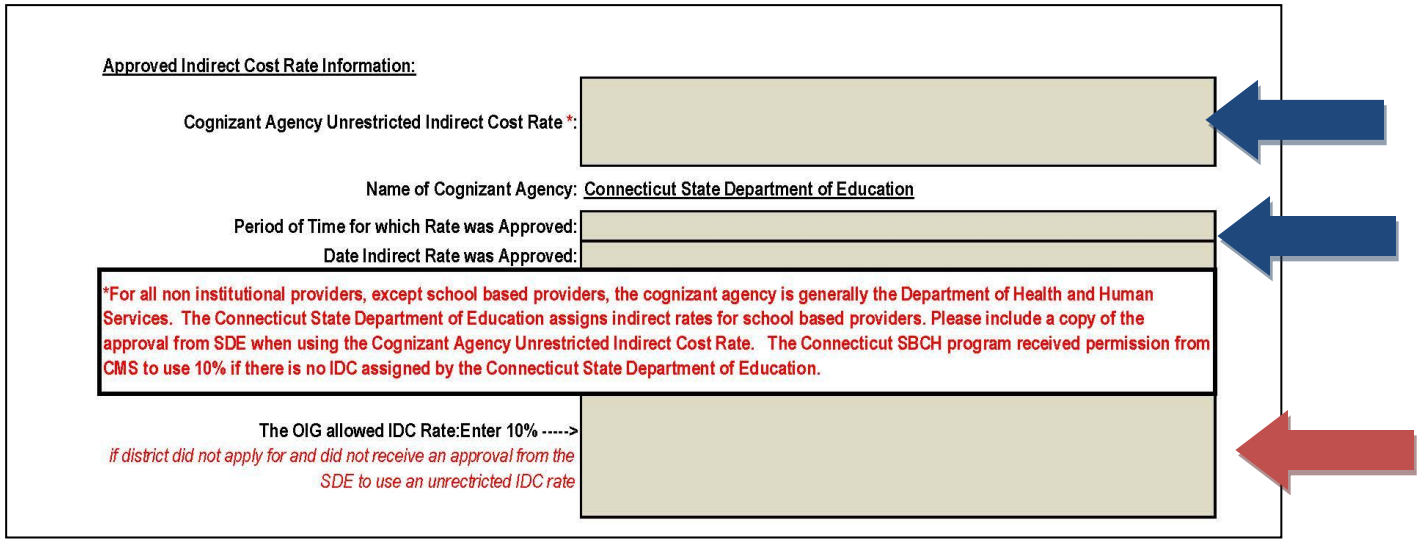
	Complete shaded cells only
School District Name:	
LEA Number:	
National Provider Identifier (NPI):	
Cost Report Period FROM Date:	7/1/2014
Cost Report Period TO Date:	6/30/2015
Submission Due Date:	
Address 1:	
Address 2:	
City, State, Zip Code	
Superintendent Name:	
Finance Director/Business Manager Name:	
Finance Director/Business Manager Phone:	
Finance Director/Business Manager Email:	
Cost Report Preparer Name:	
Cot Report Preparer Email:	
Cost Report Preparer Phone:	

Page 1b - Approved Indirect Cost Rate Information

Only **one** approved indirect cost (IDC) rate is listed in this area.

- For districts using an approved IDC from the State Department of Education, please include a pdf copy of the approval when submitting your cost report and complete the areas indicated with the blue arrows;

- For districts using the OIG allowed IDC Rate, enter 10% in the area indicated with the red arrow.



Approved Indirect Cost Rate Information:

Cognizant Agency Unrestricted Indirect Cost Rate *:

Name of Cognizant Agency: Connecticut State Department of Education

Period of Time for which Rate was Approved:

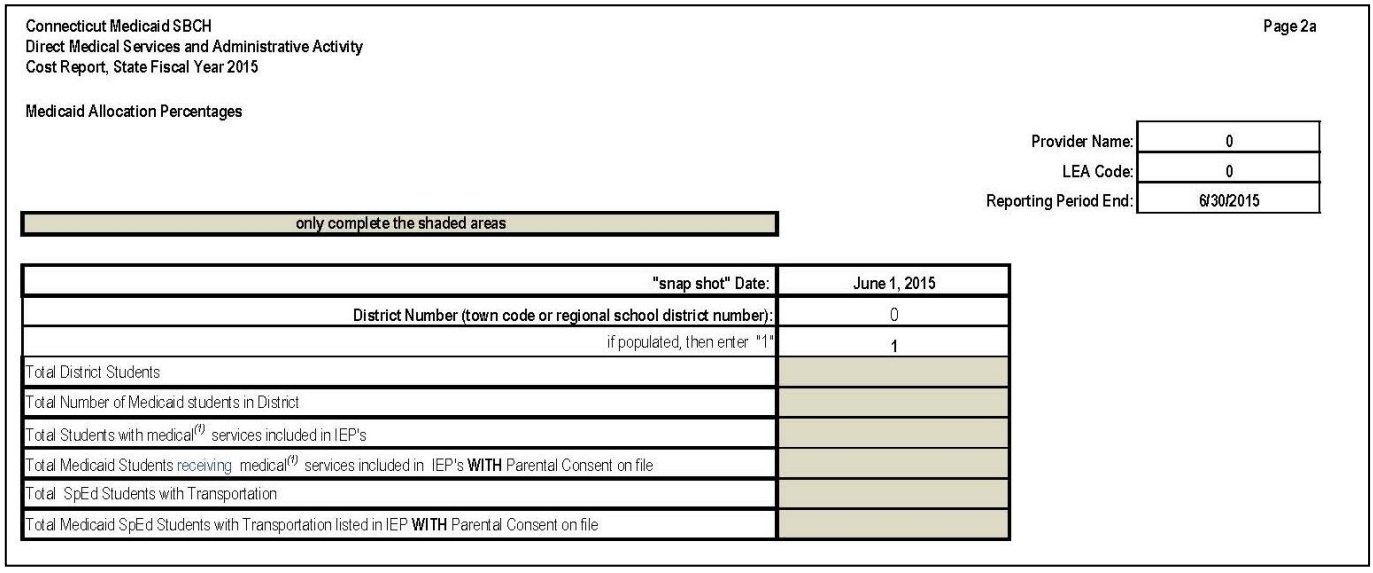
Date Indirect Rate was Approved:

*For all non institutional providers, except school based providers, the cognizant agency is generally the Department of Health and Human Services. The Connecticut State Department of Education assigns indirect rates for school based providers. Please include a copy of the approval from SDE when using the Cognizant Agency Unrestricted Indirect Cost Rate. The Connecticut SBCH program received permission from CMS to use 10% if there is no IDC assigned by the Connecticut State Department of Education.

The OIG allowed IDC Rate:Enter 10% ----->
if district did not apply for and did not receive an approval from the SDE to use an unrectricted IDC rate

Page 2a - Medicaid Alloc % detail

Districts will enter the statistical data collected as of June 1, 2015 in the shaded fields. This information should match the statistical data previously sent to and recorded by DSS. Information which does not match will be detailed in a Request for Additional Information or RAI.



Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

Page 2a

Medicaid Allocation Percentages

Provider Name:	0
LEA Code:	0
Reporting Period End:	6/30/2015

only complete the shaded areas

"snap shot" Date:	June 1, 2015
District Number (town code or regional school district number):	0
if populated, then enter "1"	1
Total District Students	
Total Number of Medicaid students in District	
Total Students with medical(1) services included in IEP's	
Total Medicaid Students receiving medical(1) services included in IEP's **WITH** Parental Consent on file	
Total SpEd Students with Transportation	
Total Medicaid SpEd Students with Transportation listed in IEP **WITH** Parental Consent on file	

Page 3 - ED001, Sch #4 expenses

Using the ED001 completed by the district and filed with the State Department of Education for the same cost period, populate the line items using column #5 (shaded column). Please also include a pdf copy of the entire ED001 submitted to the SDE for supporting documentation with the completed district cost report.

Connecticut Medicaid SBCH — **Page 3**
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

Only complete shaded areas

ED001 Report, Schedule #4
Special Education Expenditures Data
School Year: 2014-2015

Provider Name: 0
LEA Code: 0
Reporting Period End: 6/30/2015

				Complete only Column #5			
Col.#1	**Col.#2**	**Col.#3**	**Col.#4**	**Col.#5**	**Col.#6**	**Col.#7**	**Col.#8**
ED001 Schedule	Line	Code	Description	Special Ed. Per C.G.S. 10-76f (Col.2)	Allocation Bases Compensation	Allocation Bases Other Expenses	Cost Report Wks # ref
Schedule 4	404	300, 590	Purchased Services	$ 156,957	DSC=TS; Medicaid Billing=100%	n/a	**Wks #3**
Schedule 4	405	560	Special Education Tuition	$ 3,656,009	n/a	n/a	
Schedule 4	406	600	Instructional Supplies	$ 17,676	n/a	n/a	
Schedule 4	407	600	Other Supplies and Materials	$ 9,027	DSC=TS	Medicaid students with IEP Medicaid services / SpEd Enrollment	**Wks #4**
Schedule 4	408	400	Property Services	$ 350	DSC=TS	Medicaid students with IEP Medicaid services / SpEd Enrollment	**Wks #5**
Schedule 4	409	510	Special Education Transportation	$ 2,119,883	Medicaid allowable Special transportation rate= Students with IEP SpEd transport for medical reasons /All students with SpEd transport	Medicaid allowable Special transportation rate= Students with IEP SpEd transport /All students with SpEd transport	**Wks #7**
Schedule 4	410	730, 739	Equipment (Durable Medical Equipment)	$ 6,700	actual expense	Medicaid students with IEP Medicaid services / SpEd Enrollment	**Wks #6**
Schedule 4	411	890	All Other Expenditures	$ -	DSC=TS	Medicaid students with IEP Medicaid services / SpEd Enrollment	**Wks #9**
			Total	$ 5,966,602			

Page 8 - Wkst #3-404 (Purchased Professional Services)

Record the purchased professional and technical services expenses as reported on the ED001, Schedule 4, line 404 (codes 300, 590).Districts will complete the tan highlighted columns #5, #6 and #10.

- In column #5 enter the dollar amount applicable to the expense code(s) listed in column #3 and described in column #4;
- In column #6, enter “1” where services provided are 100% IEP prescribed or “0” where both IEP and non-IEP [prescribed services are provided;
- In column #10, enter the amount (if applicable) that was federally reimbursed for each of the amounts listed in column #5.

Be sure to include expenditures for specialized transportation, special education transportation monitors, and Medicaid billing vendor consultant in the applicable areas (see blue arrow). All costs listed on the worksheet must reconcile to the amount listed on the ED001.

Connecticut Medicaid SBCH — **Worksheet # 3**
Direct Medical Services and Administrative Activity — **Page 8**
Cost Report, State Fiscal Year 2015

Direct Services
Purchased Professional and Technical Services
Medicaid Reimbursable Cost

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

ONLY Complete Column #5, Column #6 and Column #10

Source: Amount Reported on ED001, Schedule #4, Line 404, Col.2 (Special Ed per CGS 10-76f) — Federal reimbursements

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8	Col #9	Col #10	Col #11	Col #12
Line	Code	SBCH-DSS Expense Code	Purchased Professional and Technical Services - Description	Purchased Professional and Technical Services Amount	Enter "1" for when delivered services are 100% IEP Prescribed Services. Enter "0" for when IEP and non-IEP prescribed services are delivered	Medicaid Services %? If Col.6 ="1" then Col.7= 100% If Col.6 ="0" then Col.7= "TS"	Statewide Direct Medicaid Services %	Medicaid Reimbursable Purchased Direct Services Cost	Federally reimbursed Purchased Professional and Technical Services Amount	Purchased Professional and Technical Services Amount applicable to Medicaid Reimbursable DSP	Pool
404	300,590	PS-010	Social Worker			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-020	Audiologist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-022	Hearing Instrument Specialist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-030	Psychologist			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-031	DPH licensed marital and family therapists			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-040	Respiratory Therapist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-050	Physical Therapist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-051	Physical Therapy Assistant			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-060	Speech-Language Therapist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-070	Nurse-APRN			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-071	Nurse-RN			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-072	Nurse-LPN			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-080	Counselor			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-090	Occupational Therapist			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-091	Occupational Therapy Assistant			TS	31.20%	$ -		$ -	Therapy
404	300,590	PS-100	chiropractors, licensed; natureopaths, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-101	Optometrist, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-102	Osteopaths, licensed; Physician Assistant, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-103	Physician, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-104	Podiatrist, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-105	Psychiatrist, licensed			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-801	Medicaid Billing Vendor			TS	36.30%	$ -		$ -	Nursing
404	300,590	PS-900	Assistive Technology Consultant, Audiometrist			TS	31.20%	$ -		$ -	Therapy
			Purchased Services-Direct Services	$ -				s/t $ -	To line 6a->	$ -	

PS-700	Specialized Transportation	---------->	$ -
PS-701	Special Education Transportation Monitors	---------->	$ -
PS-801	Medicaid Billing Vendor-Medicaid Consultant	To: Certification Line 2--->	$ -
	Purchased Services not related to the Medicaid SBCH		
	Total Purchased Services		$ -
	ED001, Schedule #4, Line 404, Col.2 (Special Ed per CGS 10-76f)		$ -
	Reconciliation (s/b 0.00)		$ -

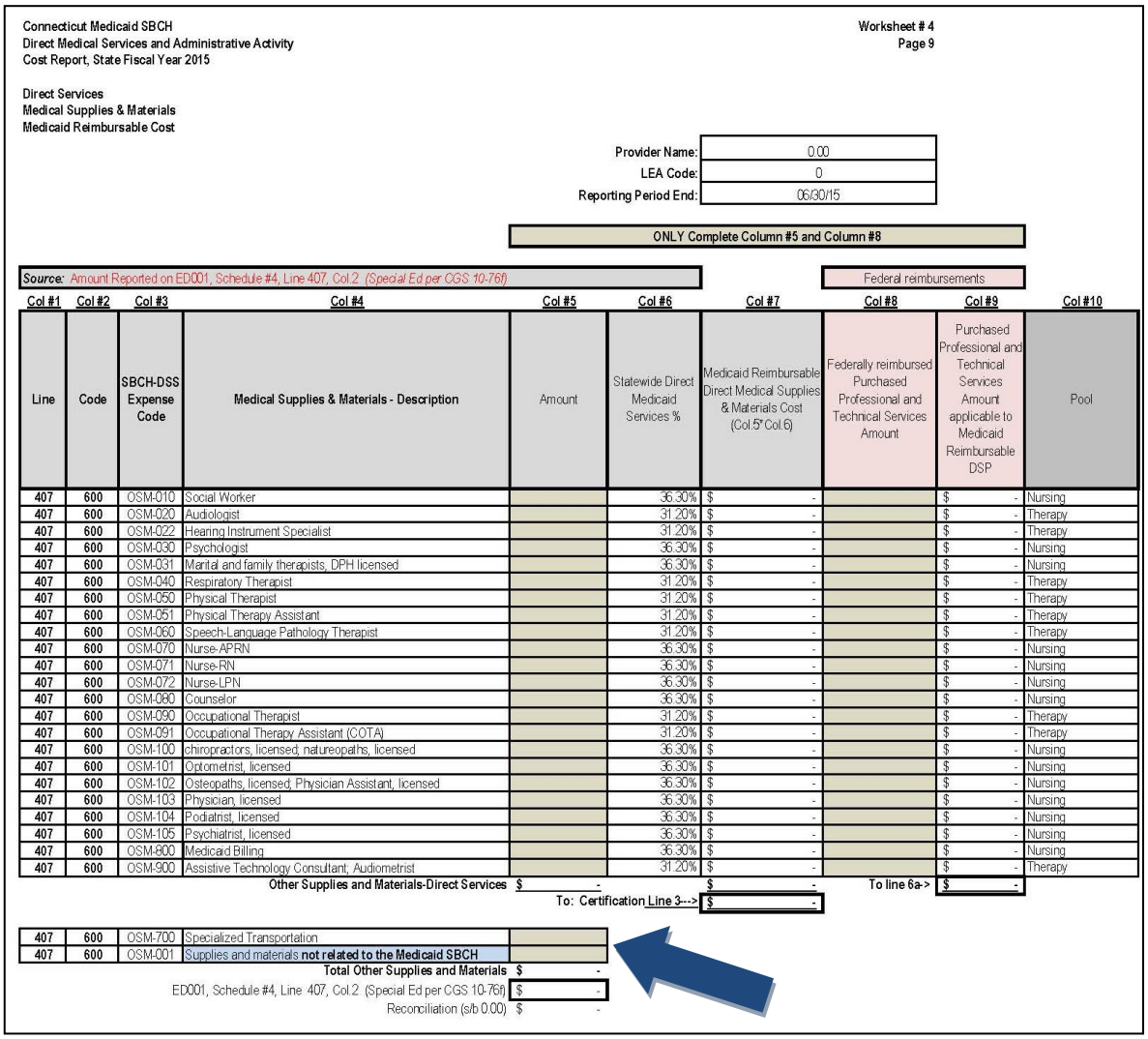
Page 9 - Wkst #4-407 (Supplies & Materials)

Record the supplies and materials expenses as reported on the ED001, Schedule 4, line 407 (code 600). Districts will complete the tan highlighted columns #5 and #8.

- In column #5 enter the dollar amount applicable to the expense code(s) listed in column #3 and described in column #4;

- In column #10, enter the amount (if applicable) that was federally reimbursed for each of the amounts listed in column #5.

Be sure to include expenditures for specialized transportation and supplies and materials not related to the Medicaid SBCH program in the applicable areas. (see blue arrow). All costs listed on the worksheet must reconcile to the amount listed on the ED001.



Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

Worksheet # 4
Page 9

Direct Services
Medical Supplies & Materials
Medicaid Reimbursable Cost

Provider Name: 0.00
LEA Code: 0
Reporting Period End: 06/30/15

ONLY Complete Column #5 and Column #8

Source: Amount Reported on ED001, Schedule #4, Line 407, Col.2 *(Special Ed per CGS 10-76f)*

Federal reimbursements

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8	Col #9	Col #10
Line	Code	SBCH-DSS Expense Code	Medical Supplies & Materials - Description	Amount	Statewide Direct Medicaid Services %	Medicaid Reimbursable Direct Medical Supplies & Materials Cost (Col.5*Col.6)	Federally reimbursed Purchased Professional and Technical Services Amount	Purchased Professional and Technical Services Amount applicable to Medicaid Reimbursable DSP	Pool
407	600	OSM-010	Social Worker		36.30%	$ -		$ -	Nursing
407	600	OSM-020	Audiologist		31.20%	$ -		$ -	Therapy
407	600	OSM-022	Hearing Instrument Specialist		31.20%	$ -		$ -	Therapy
407	600	OSM-030	Psychologist		36.30%	$ -		$ -	Nursing
407	600	OSM-031	Marital and family therapists, DPH licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-040	Respiratory Therapist		31.20%	$ -		$ -	Therapy
407	600	OSM-050	Physical Therapist		31.20%	$ -		$ -	Therapy
407	600	OSM-051	Physical Therapy Assistant		31.20%	$ -		$ -	Therapy
407	600	OSM-060	Speech-Language Pathology Therapist		31.20%	$ -		$ -	Therapy
407	600	OSM-070	Nurse-APRN		36.30%	$ -		$ -	Nursing
407	600	OSM-071	Nurse-RN		36.30%	$ -		$ -	Nursing
407	600	OSM-072	Nurse-LPN		36.30%	$ -		$ -	Nursing
407	600	OSM-080	Counselor		36.30%	$ -		$ -	Nursing
407	600	OSM-090	Occupational Therapist		31.20%	$ -		$ -	Therapy
407	600	OSM-091	Occupational Therapy Assistant (COTA)		31.20%	$ -		$ -	Therapy
407	600	OSM-100	chiropractors, licensed; naturopaths, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-101	Optometrist, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-102	Osteopaths, licensed; Physician Assistant, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-103	Physician, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-104	Podiatrist, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-105	Psychiatrist, licensed		36.30%	$ -		$ -	Nursing
407	600	OSM-800	Medicaid Billing		36.30%	$ -		$ -	Nursing
407	600	OSM-900	Assistive Technology Consultant; Audiometrist		31.20%	$ -		$ -	Therapy
			Other Supplies and Materials-Direct Services	$ -		$ -	To line 6a->	$ -	
				To: Certification Line 3--->		$ -			
407	600	OSM-700	Specialized Transportation						
407	600	OSM-001	Supplies and materials not related to the Medicaid SBCH						
			Total Other Supplies and Materials	$ -					
			ED001, Schedule #4, Line 407, Col.2 (Special Ed per CGS 10-76f)	$					
			Reconciliation (s/b 0.00)	$ -					

Page 10 - Wkst #5-408 (Purchased Property Services)

Record the purchased property services expenses as reported on the ED001, Schedule 4, line 408 (code 400). Districts will complete the tan highlighted columns #5 and #8.

- In column #5 enter the dollar amount applicable to the expense code(s) listed in column #3 and described in column #4;
- In column #10, enter the amount (if applicable) that was federally reimbursed for each of the amounts listed in column #5.

Be sure to include expenditures for specialized transportation and supplies and materials not related to the Medicaid SBCH program in the applicable areas. (see blue arrow). All costs listed on the worksheet must reconcile to the amount listed on the ED001.

Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
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Worksheet # 5
Page 10

Direct Services
Purchased Property Services
Medicaid Reimbursable Cost

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

ONLY Complete Column #5 and Column #8

Source: Amount Reported on ED001, Schedule #4, Line 408, Col.2 *(Special Ed per CGS 10-76f)*

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Federal reimbursements Col #8	Col #9	Col #10
Line	Code	SBCH-DSS Expense Code	Purchased Property Services - Description	Amount	Statewide Direct Medicaid Services %	Direct Cost of the Purchsed Property Services (Col.5*Col.6)	Federally reimbursed Purchased Professional and Technical Services Amount	Purchased Professional and Technical Services Amount applicable to Medicaid Reimbursable DSP	Pool
408	400	PPS-010	Social Worker		36.30%	$ -		$ -	Nursing
408	400	PPS-020	Audiologist		31.20%	$ -		$ -	Therapy
408	400	PPS-022	Hearing Instrument Specialist		31.20%	$ -		$ -	Therapy
408	400	PPS-030	Psychologist		36.30%	$ -		$ -	Nursing
408	400	PPS-031	Marital and family therapists, DPH licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-040	Respiratory Therapist		31.20%	$ -		$ -	Therapy
408	400	PPS-050	Physical Therapist		31.20%	$ -		$ -	Therapy
408	400	PPS-051	Physical Therapy Assistant		31.20%	$ -		$ -	Therapy
408	400	PPS-060	Speech-Language Pathology Therapist		31.20%	$ -		$ -	Therapy
408	400	PPS-070	Nurse-APRN		36.30%	$ -		$ -	Nursing
408	400	PPS-071	Nurse-RN		36.30%	$ -		$ -	Nursing
408	400	PPS-072	Nurse-LPN		36.30%	$ -		$ -	Nursing
408	400	PPS-080	Counselor		36.30%	$ -		$ -	Nursing
408	400	PPS-090	Occupational Therapist		31.20%	$ -		$ -	Therapy
408	400	PPS-091	Occupational Therapy Assistant (COTA)		31.20%	$ -		$ -	Therapy
408	400	PPS-100	chiropractors, licensed; natureopaths, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-101	Optometrist, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-102	Osteopaths, licensed; Physician Assistant, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-103	Physician, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-104	Podiatrist, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-105	Psychiatrist, licensed		36.30%	$ -		$ -	Nursing
408	400	PPS-800	Medicaid Billing		36.30%	$ -		$ -	Nursing
408	400	PPS-900	Assistive Technology Consultant; Audiometrist		31.20%	$ -	$ -	$ -	Therapy
			Purchased Property Services-Direct Services	$ -		$ -	To line 6a->	$ -	
					To: Certification Line 4--->	$ -			
408	400	PPS-700	Specialized Transportation						
408	400	PPS-001	Purchased Property Services-not related to the Medicaid SBCH						
			Purchased Property Services	$ -					
			ED001, Schedule #4, Line 408 Col.2 (Special Ed per CGS 10-76f)	$ -					
			Reconciliation (s/b 0.00)	$ -					

Page 11 - Wkst #7 – Special Education Transportation

Record the special education transportation costs as reported on the ED001, Schedule 4, line 409 (code 510). Districts will complete the tan highlighted fields in columns #5, #6 and #7. The top portion of the worksheet (lines 12-30) will auto populate based upon information entered within the worksheet, registers, and other tabs within the workbook.

Note: Only districts who have maintained/retained transportation logs clearly indicating students who rode the bus to school and received an IEP-prescribed SBCH covered service on the identified day may seek to claim special education transportation as ***an administrative cost.***

CMS provides the following guidance pertaining to Transportation:
(sources - Medicaid and School Health: A technical Assistance Guide, August 1997; CMS bulletin dated May 21, 1999)

- *A child with special education needs under IDEA who rides the regular school but to school with other non-disabled children in his/her neighborhood should not have transportation listed in their IEP and the cost of that bus ride should not be billed to Medicaid;*
- *If a child requires transportation in a vehicle to serve the needs of the disabled, including a specially adapted school bus, that transportation may be billed to Medicaid if the need for that specialized transportation is identified in the IEP. In addition, if a child resides in an area that does not have school bus transportation (such as those areas in close proximity to a school) but has a medical need for transportation that is noted in their IEP, that transportation may also be billed to Medicaid;*
- *As always, transportation from the school to a provider in the community may also be billed to Medicaid;*
- *The Medicaid program may pay for transportation to school based services for children under IDEA when both of the following conditions are met: (1) the child receives transportation to obtain a Medicaid-covered service (other than transportation), and (2) both the Medicaid0covered service and the need for transportation are included in the child's IEP or IFSP.*

Total Special Education Transportation Cost Summary

Paid Salary/ Compensation Amount	$ -
Fringe Benefits (Employer Share) Amount	$ -
Other Cost	$ -
S/T	$ -
Annual Average Medicaid Allowable Specialized Transportation Rate %	#DIV/0!
Gross Special Education Transportation Cost	#DIV/0!
To: Certification Line 16--->	#DIV/0!

Line #		Col #6
1	Annual average of the Medicaid SpEd Students with Transportation listed in IEP	#DIV/0!
2	Annual average of the Number of Enrolled SpEd students who utilized specialized transportation (Total SpEd Students with Transportation)	#DIV/0!
3	Annual Average Specialized Transportation Rate %= line 1 / line 2	#DIV/0!

	Col #1	Col #2	Col #3	Col #4	Col #5	Col #6
	source: 21-REGISTER-Transport S&W, FB					
			SBCH Cost Report Expenditure Code	Special Education Transportation	Paid Salary/ Compensation Amount	Fringe Benefits (Employee Benefits) Amount
4			SW-700	Special Education Transportation - Driver Compensation	$ -	$ -
5			SW-701	Special Education Transportation - Monitors Compensation	$ -	$ -
6					$ -	$ -

- In column #5 enter the paid salary/compensation amount for special education transportation drivers/van drivers and special education transportation monitors. The total for this line will automatically calculate;

- In column #10, enter the fringe benefits-employer share for special education transportation drivers/van drivers and special education transportation monitors. The total for this line will automatically calculate;

- In column #7, enter the expenses associated with special education transportation fuel, supplies/parts, vehicle maintenance as stated in A-87 guide, contracts, rental and depreciation. The district may also list other items but those items must include a description in the **"specify"** field.

Expenses included on worksheets 3-404, 4-408, and 5-408 will automatically carry forward to the worksheet on lines 18-20. All costs listed on the worksheet must reconcile to the amount listed on the ED001.

						Complete Col. #5, Col. #6 and Col.#7		
	Col #1	Col #2	Col #3	Col #4		Col #5	Col #6	Col #7
	source: ED001, Schedule #4.							
	ED001, Schedule #4		SBCH Cost Report Expenditure Code	Special Education Transportation		Paid Salary/ Compensation Amount	Fringe Benefits - Employer Share Amount	Cost
	Line	Code						
7	409	510	TRN-700	Special EducationTransportation Drivers/Van Drivers				0
8	409	510	TRN-701	Special EducationTransportation Monitors				0
9	409	510	TRN-021	Special Education Transportation - Insurance				
10	409	510	TRN-022	Special Education Transportation - Fuel				
11	409	510	TRN-030	Special Education Transportation -Supplies/Parts				
12	409	510	TRN-031	Special Education Transportation - Vehicle Maintenance				
13	409	510	TRN-032	Special Education Transportation - Contract				
14	409	510	TRN-032	Special Education Transportation - other *specify*				
15	409	510	TRN-032	Special Education Transportation - other *specify*				
16	409	510	TRN-080	Special Education Transportation - Vehicle Rental				
17	409	510	TRN-090	Special Education Transportation - Depreciation				
18	404	300,590	PS-700	Special EducationTransportation Drivers/Van Drivers				0
19	404	300,590	PS-701	Special EducationTransportation Monitors				0
20	408	400	PPS-700	Special Education Transportation				0
21						0	0	0
					ED001, Schedule #4, Line 409, Col.2 (Special Ed per CGS 10-76f)			$ -
					Reconciliation (s/b 0.00)			$ -

Page 11d – Client count serv+transp

This tab is completed by those districts who have met the requirements for transportation as stated on page 16. Districts will complete column #1 and column #5 indicating for each student listed whether or not transportation services are prescribed in the student IEP.

Connecticut Medicaid SBCH **Page 11d**
Direct Medical Services and Administrative Activity
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SBCH - Administrative Cost Claim
CAP Specialized Transportation
Cost Reporting Period Ended 6/30/2015
Unduplicated Count of the Medicaid Service Days

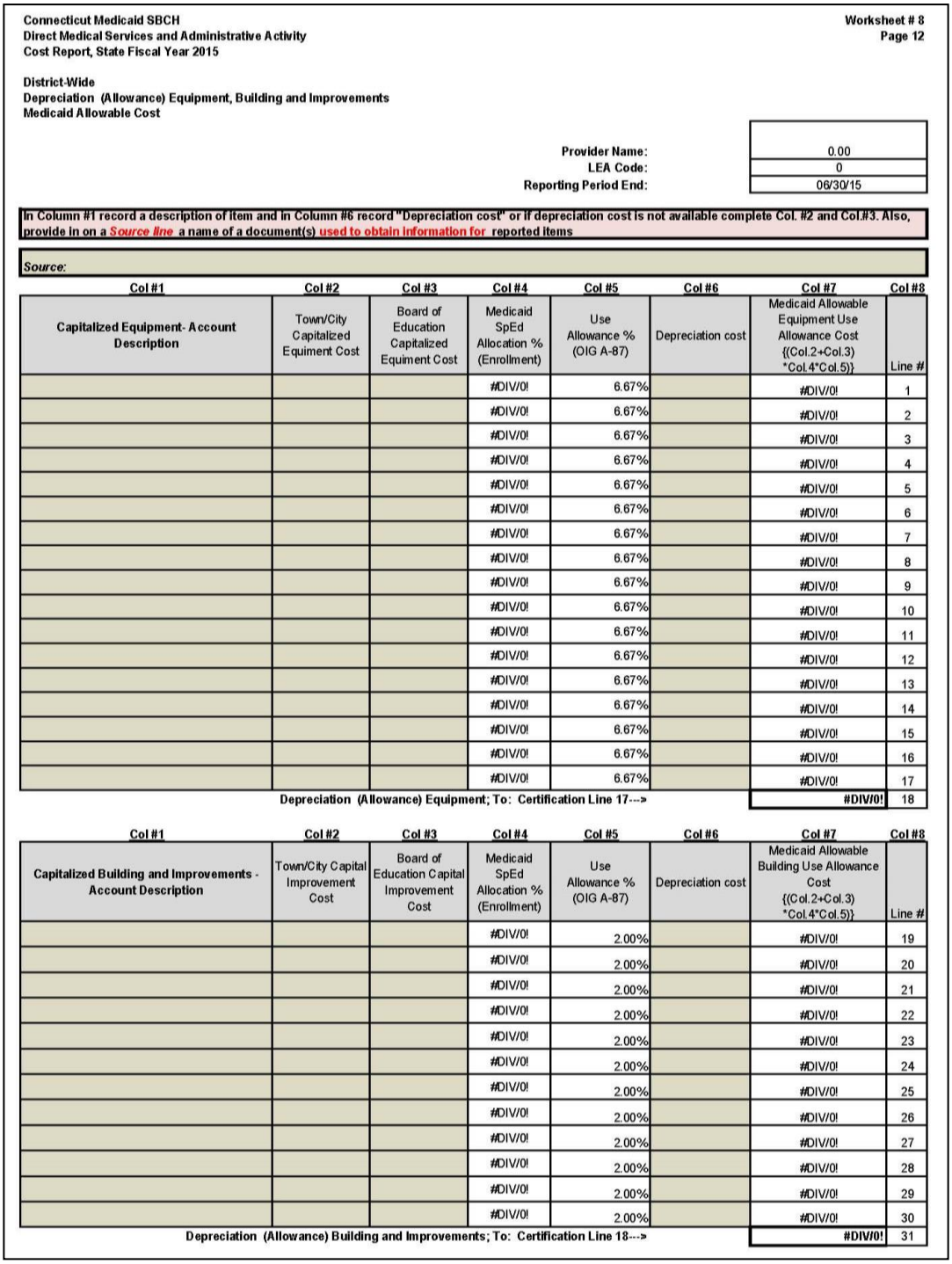
Total number of school days when IEP prescribed medical service and transportaton was provided to Medicaid eligible students==========>	#N/A	<= source documentation: DW report of paid claims and IEP records
Total count of medicaid eligible students with specialized transportation & Medicaid service in IEP ========>	0	

SBCH-Paid claims
0
Other Cost (Purchased services-all inclusive contract)

Column #1	Column #2	Column #3	Column #4	Column #5	Column #6
Participant ID (Medicaid Number)	Days of Service Unduplicated Count (see TAB titled "*DW client count w paid serv*")			Specialized Transportation prescribed in student's IEP, please, **type in an answer Y=yes or N=no**	Total count of medicaid eligible students that had specialized transportation and Medicaid service(s) prescribed in their IEP during the cost period
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				
	#N/A				

Page 12 - Wkst #8 – Depreciation Allowance

Record the depreciation (allowance) equipment, building and improvements applicable to the district for the specified reporting period. Districts will complete the tan highlighted fields in columns #1, #2, #3, and #6. In addition to the columns, districts must indicate the source document used to obtain the information for the reported items. This information should be listed in the field labeled “source”. Column #7 will calculate the district’s allowed Medicaid applicable depreciation cost (use allowance cost). Districts should refer to OMB circular A-87 “Depreciation and use allowance” when completing this worksheet.



Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

Worksheet # 8
Page 12

District-Wide
Depreciation (Allowance) Equipment, Building and Improvements
Medicaid Allowable Cost

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

In Column #1 record a description of item and in Column #6 record "Depreciation cost" or if depreciation cost is not available complete Col. #2 and Col.#3. Also, provide in on a *Source line* a name of a document(s) used to obtain information for reported items

Source:

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8
Capitalized Equipment- Account Description	Town/City Capitalized Equiment Cost	Board of Education Capitalized Equiment Cost	Medicaid SpEd Allocation % (Enrollment)	Use Allowance % (OIG A-87)	Depreciation cost	Medicaid Allowable Equipment Use Allowance Cost {(Col.2+Col.3) *Col.4*Col.5)}	Line #
			#DIV/0!	6.67%		#DIV/0!	1
			#DIV/0!	6.67%		#DIV/0!	2
			#DIV/0!	6.67%		#DIV/0!	3
			#DIV/0!	6.67%		#DIV/0!	4
			#DIV/0!	6.67%		#DIV/0!	5
			#DIV/0!	6.67%		#DIV/0!	6
			#DIV/0!	6.67%		#DIV/0!	7
			#DIV/0!	6.67%		#DIV/0!	8
			#DIV/0!	6.67%		#DIV/0!	9
			#DIV/0!	6.67%		#DIV/0!	10
			#DIV/0!	6.67%		#DIV/0!	11
			#DIV/0!	6.67%		#DIV/0!	12
			#DIV/0!	6.67%		#DIV/0!	13
			#DIV/0!	6.67%		#DIV/0!	14
			#DIV/0!	6.67%		#DIV/0!	15
			#DIV/0!	6.67%		#DIV/0!	16
			#DIV/0!	6.67%		#DIV/0!	17
Depreciation (Allowance) Equipment; To: Certification Line 17---»						#DIV/0!	18

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8
Capitalized Building and Improvements - Account Description	Town/City Capital Improvement Cost	Board of Education Capital Improvement Cost	Medicaid SpEd Allocation % (Enrollment)	Use Allowance % (OIG A-87)	Depreciation cost	Medicaid Allowable Building Use Allowance Cost {(Col.2+Col.3) *Col.4*Col.5)}	Line #
			#DIV/0!	2.00%		#DIV/0!	19
			#DIV/0!	2.00%		#DIV/0!	20
			#DIV/0!	2.00%		#DIV/0!	21
			#DIV/0!	2.00%		#DIV/0!	22
			#DIV/0!	2.00%		#DIV/0!	23
			#DIV/0!	2.00%		#DIV/0!	24
			#DIV/0!	2.00%		#DIV/0!	25
			#DIV/0!	2.00%		#DIV/0!	26
			#DIV/0!	2.00%		#DIV/0!	27
			#DIV/0!	2.00%		#DIV/0!	28
			#DIV/0!	2.00%		#DIV/0!	29
			#DIV/0!	2.00%		#DIV/0!	30
Depreciation (Allowance) Building and Improvements; To: Certification Line 18---»						#DIV/0!	31

District-Wide
Depreciation (Allowance) Equipment, Building and Improvements
Medicaid Allowable Cost

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

In Column #1 record a description of item and in Column #6 record "Depreciation cost" or if depreciation cost is not available complete Col. #2 and Col.#3. Also, provide in on a *Source line* a name of a document(s) used to obtain information for reported items

Source:

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8
Capitalized Equipment- Account Description	Town/City Capitalized Equiment Cost	Board of Education Capitalized Equiment Cost	Medicaid SpEd Allocation % (Enrollment)	Use Allowance % (OIG A-87)	Depreciation cost	Medicaid Allowable Equipment Use Allowance Cost {(Col.2+Col.3) *Col.4*Col.5)}	Line #
			#DIV/0!	6.67%		#DIV/0!	1
			#DIV/0!	6.67%		#DIV/0!	2
			#DIV/0!	6.67%		#DIV/0!	3
			#DIV/0!	6.67%		#DIV/0!	4
			#DIV/0!	6.67%		#DIV/0!	5
			#DIV/0!	6.67%		#DIV/0!	6
			#DIV/0!	6.67%		#DIV/0!	7
			#DIV/0!	6.67%		#DIV/0!	8
			#DIV/0!	6.67%		#DIV/0!	9
			#DIV/0!	6.67%		#DIV/0!	10
			#DIV/0!	6.67%		#DIV/0!	11
			#DIV/0!	6.67%		#DIV/0!	12
			#DIV/0!	6.67%		#DIV/0!	13
			#DIV/0!	6.67%		#DIV/0!	14
			#DIV/0!	6.67%		#DIV/0!	15
			#DIV/0!	6.67%		#DIV/0!	16
			#DIV/0!	6.67%		#DIV/0!	17
			Depreciation (Allowance) Equipment; To: Certification Line 17--->			#DIV/0!	18

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8
Capitalized Building and Improvements - Account Description	Town/City Capital Improvement Cost	Board of Education Capital Improvement Cost	Medicaid SpEd Allocation % (Enrollment)	Use Allowance % (OIG A-87)	Depreciation cost	Medicaid Allowable Building Use Allowance Cost {(Col.2+Col.3) *Col.4*Col.5)}	Line #
			#DIV/0!	2.00%		#DIV/0!	19
			#DIV/0!	2.00%		#DIV/0!	20
			#DIV/0!	2.00%		#DIV/0!	21
			#DIV/0!	2.00%		#DIV/0!	22
			#DIV/0!	2.00%		#DIV/0!	23
			#DIV/0!	2.00%		#DIV/0!	24
			#DIV/0!	2.00%		#DIV/0!	25
			#DIV/0!	2.00%		#DIV/0!	26
			#DIV/0!	2.00%		#DIV/0!	27
			#DIV/0!	2.00%		#DIV/0!	28
			#DIV/0!	2.00%		#DIV/0!	29
			#DIV/0!	2.00%		#DIV/0!	30
			Depreciation (Allowance) Building and Improvements; To: Certification Line 18--->			#DIV/0!	31

Page 13 - Wkst #9-411 – All Other Expenses

Record all other expenses as reported on the ED001, Schedule 4, line 411 (code 890). Districts will complete the tan highlighted fields in columns #5 and #8.

- In column #5 enter the dollar amount applicable to the expense code(s) listed in column #3 and described in column #4;
- In column #8, enter the amount (if applicable) that was federally reimbursed for each of the amounts listed in column #5.

Be sure to include expenditures for Medicaid billing and miscellaneous expenditures-not related to the Medicaid SBCH program in the applicable areas. (see blue arrow). All costs listed on the worksheet must reconcile to the amount listed on the ED001.

Connecticut Medicaid SBCH
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Worksheet # 9
Page 13

All Other Expenditures
Medicaid Reimbursable Cost

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

ONLY Complete Column #5 and Column #8

Source: Amount Reported on ED001, Schedule #4, Line 411, Col.2 *(Special Ed per CGS 10-76f)*

Federal reimbursements

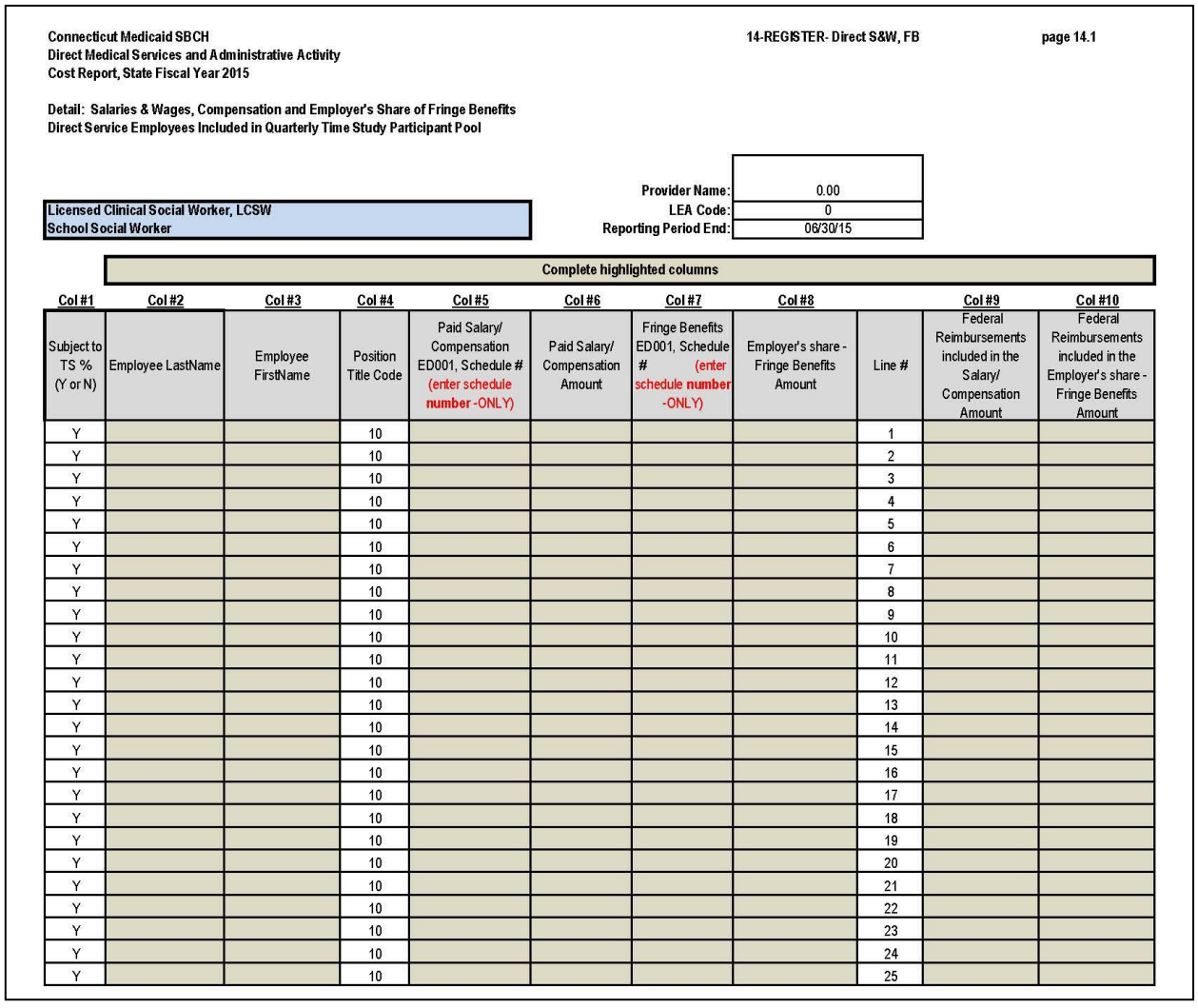
Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8	Col #9	Col #10
ED001, Sched.#4		SBCH-DSS Expense Code	All Other Expenditures - Description	Amount	Statewide Direct Medicaid Services %	Medicaid Reimbursable Direct All Other Expenditures (Col.5*Col.6)	Federally reimbursed Purchased Professional and Technical Services Amount	Purchased Professional and Technical Services Amount applicable to Medicaid Reimbursable DSP	Pool
Line	Code								
411	890	MSC-010	Social Worker		36.30%	$ -		$ -	Nursing
411	890	MSC-020	Audiologist		31.20%	$ -		$ -	Therapy
411	890	MSC-022	Hearing Instrument Specialist		31.20%	$ -		$ -	Therapy
411	890	MSC-030	Psychologist		36.30%	$ -		$ -	Nursing
411	890	MSC-031	Marital and family therapists, DPH licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-040	Respiratory Therapist		31.20%	$ -		$ -	Therapy
411	890	MSC-050	Physical Therapist		31.20%	$ -		$ -	Therapy
411	890	MSC-051	Physical Therapy Assistant		31.20%	$ -		$ -	Therapy
411	890	MSC-060	Speech-Language Pathology Therapist		31.20%	$ -		$ -	Therapy
411	890	MSC-070	Nurse-APRN		36.30%	$ -		$ -	Nursing
411	890	MSC-071	Nurse-RN		36.30%	$ -		$ -	Nursing
411	890	MSC-072	Nurse-LPN		36.30%	$ -		$ -	Nursing
411	890	MSC-080	Counselor		36.30%	$ -		$ -	Nursing
411	890	MSC-090	Occupational Therapist		31.20%	$ -		$ -	Therapy
411	890	MSC-091	Occupational Therapy Assistant (COTA)		31.20%	$ -		$ -	Therapy
411	890	MSC-100	chiropractors, licensed; natureopaths, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-101	Optometrist, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-102	Osteopaths, licensed; Physician Assistant, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-103	Physician, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-104	Podiatrist, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-105	Psychiatrist, licensed		36.30%	$ -		$ -	Nursing
411	890	MSC-800	Medicaid Billing		36.30%	$ -		$ -	Nursing
411	890	MSC-900	Assistive Technology Consultant; Audiometrist		31.20%	$ -		$ -	Therapy
			All Other Expenditures-Direct Services	$ -		$ -	**To line 6a->**	$ -	
					To: Certification Line 5--->	$ -			
411	890	MSC-800	Medicaid Billing						
411	890	MSC-002	**Miscellaneous Expenditures-not related to the Medicaid SBCH program**						
			Total All Other Expenditures	$ -					
			ED001, Schedule #4, Line 411, Col.2 (Special Ed per CGS 10-76f)	$ -					
			Reconciliation (s/b 0.00)	$ -					

Pages 14 through 16 - REGISTERS

Using the provided Employee Listing, districts will enter the salary and fringe benefit amounts, and the amount of each with is federally reimbursed for the Direct Service Providers, Medicaid Billing Personnel, Administrative Program Support Staff, and Transportation Drivers/Van Drivers and Transportation Monitors on the applicable Register. Please refer to the section on page 8 referring to employee listings. Transportation Drivers/Van Drivers and Transportation Monitors will not be included in the employee listing as they are not included as part of the RMTS.

For staff listed with a position code-ADMIN, these employees should be included only on the Administrative register.

> *For example, John Smith was listed for Q2, Q3, and Q4 as a Social Worker with the position code 30-ADMIN and cost pool 1. John Smith should be listed on the Administrative register as he was listed throughout the year as an Administrative only provider (one who does not submit Medicaid claims). John Smith would not be listed on REGISTER(10)Social Worker.*



Connecticut Medicaid SBCH — **14-REGISTER- Direct S&W, FB** — **page 14.1**
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

Detail: Salaries & Wages, Compensation and Employer's Share of Fringe Benefits
Direct Service Employees Included in Quarterly Time Study Participant Pool

Licensed Clinical Social Worker, LCSW
School Social Worker

Provider Name: 0.00
LEA Code: 0
Reporting Period End: 06/30/15

Complete highlighted columns

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8		Col #9	Col #10
Subject to TS % (Y or N)	Employee LastName	Employee FirstName	Position Title Code	Paid Salary/ Compensation ED001, Schedule # (enter schedule number -ONLY)	Paid Salary/ Compensation Amount	Fringe Benefits ED001, Schedule # (enter schedule number -ONLY)	Employer's share - Fringe Benefits Amount	Line #	Federal Reimbursements included in the Salary/ Compensation Amount	Federal Reimbursements included in the Employer's share - Fringe Benefits Amount
Y			10					1		
Y			10					2		
Y			10					3		
Y			10					4		
Y			10					5		
Y			10					6		
Y			10					7		
Y			10					8		
Y			10					9		
Y			10					10		
Y			10					11		
Y			10					12		
Y			10					13		
Y			10					14		
Y			10					15		
Y			10					16		
Y			10					17		
Y			10					18		
Y			10					19		
Y			10					20		
Y			10					21		
Y			10					22		
Y			10					23		
Y			10					24		
Y			10					25		

Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

15-REGISTER- Administrative Staff; S&W, FB

Detail: Salaries & Wages, Compensation and Employer's Share of Fringe Benefits

Administrative Employees Included in Quarterly Time Study Participant Pool

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

Administrative Staff

Complete highlighted columns

Col #1	Col #2	Col #3	Col #4	Col #5	Col #6	Col #7	Col #8		Col #9	Col #10
Subject to TS % (Y or N)	Employee LastName	Employee FirstName	Position Title Code (201 - 204)	Paid Salary/ Compensation ED001, Schedule # (enter schedule number -ONLY)	Paid Salary/ Compensation Amount	Fringe Benefits ED001, Schedule # (enter schedule number -ONLY)	Employer's share - Fringe Benefits Amount	Line #	Federal Reimbursements included in the Salary/ Compensation Amount	Federal Reimbursements included in the Employer's share - Fringe Benefits Amount
Y								1		
Y								2		
Y								3		
Y								4		
Y								5		
Y								6		
Y								7		
Y								8		
Y								9		
Y								10		
Y								11		
Y								12		
Y								13		
Y								14		

Connecticut Medicaid SBCH
Direct Medical Services and Administrative Activity
Cost Report, State Fiscal Year 2015

16-REGISTER- Specialized Transportation Employees; S&W, FB

Detail: Salaries & Wages, Compensation and Employer's Share of Fringe Benefits
School Transportation Special Services Employees

Provider Name:	0.00
LEA Code:	0
Reporting Period End:	06/30/15

Special Education Transportation Drivers/Van Drivers
Special Education Transportation Monitors

Complete highlighted columns

Col #1	Col #2	Col #3	Col #4	Transportation Drivers/Van Drivers Allocation		Col #5	Col #6	Col #7	Col #8		
Subject to TS % (Y or N)	Employee LastName	Employee FirstName	Position Title Code	Paid Salary/ Compensation Amount Allocatd to Transportation (Col.6)	Fringe Benefits (Employee Benefits) Amount Allocatd to Transportation (Col.8)	Paid Salary/ Compensation ED001, Schedule # (enter only schedule number from ED001 report)	Paid Salary/ Compensation Amount	Fringe Benefits ED001, Schedule # (enter only schedule number from ED001 report)	Employer's share -Fringe Benefits Amount		Line #
N			SW-700	$0.00	$0.00					100.00%	1
N			SW-700	$0.00	$0.00					100.00%	2
N			SW-700	$0.00	$0.00					100.00%	3
N			SW-700	$0.00	$0.00					100.00%	4
N			SW-700	$0.00	$0.00					100.00%	5
N			SW-700	$0.00	$0.00					100.00%	6
N			SW-700	$0.00	$0.00					100.00%	7
N			SW-700	$0.00	$0.00					100.00%	8
N			SW-700	$0.00	$0.00					100.00%	9
N			SW-700	$0.00	$0.00					100.00%	10
N			SW-700	$0.00	$0.00					100.00%	11
N			SW-700	$0.00	$0.00					100.00%	12
N			SW-700	$0.00	$0.00					100.00%	13
N			SW-700	$0.00	$0.00					100.00%	14
N			SW-700	$0.00	$0.00					100.00%	15
N			SW-700	$0.00	$0.00					100.00%	16
N			SW-700	$0.00	$0.00					100.00%	17
N			SW-700	$0.00	$0.00					100.00%	18
N			SW-700	$0.00	$0.00					100.00%	19
	Special EducationTransportation Drivers/Van Drivers			$0	$0		0		0		20

Complete highlighted columns

Specialized Transportation Monitors

Col #1	Col #2	Col #3	Col #4	Transportation Monitors Allocation		Col #5	Col #6	Col #7	Col #8	Col #9	Col #10	Col #11	Col #12	Col #13	
Subject to TS % (Y or N)	Employee LastName	Employee FirstName	Position Title Code	Paid Salary/ Compensation Amount Allocatd to Transportation (Col.6 x Col.9)	Fringe Benefits (Employee Benefits) Amount Allocatd to Transportation (Col.8 x Col.9)	Paid Salary/ Compensation ED001, Schedule # (enter here only the ED001 schedule number)	Paid Salary/ Compensation Amount	Fringe Benefits ED001, Schedule #	Fringe Benefits (Employee Benefits) Amount	allocation base (Col.11*5) / col.12	Does Transportation Monitor provide other duties besides riding on the bus with students (enter Yes or No)	Record of how many hours a day Transportation Monitor spend on the bus with students	Record Transportation Monitor's weekly paid hours	Record of how many paid days are captured under the salary recorded in column #6 (enter actual days or 181 if days paid are equyal to school year days)	Line #
N			SW-701	$ -	$ -					0.00%					21
N			SW-701	$ -	$ -					0.00%					22
N			SW-701	$ -	$ -					0.00%					23
N			SW-701	$ -	$ -					0.00%					24
N			SW-701	$ -	$ -					0.00%					25
N			SW-701	$ -	$ -					0.00%					26
N			SW-701	$ -	$ -					0.00%					27
N			SW-701	$ -	$ -					0.00%					28
N			SW-701	$ -	$ -					0.00%					29
N			SW-701	$ -	$ -					0.00%					30
N			SW-701	$ -	$ -					0.00%					31
N			SW-701	$ -	$ -					0.00%					32
N			SW-701	$ -	$ -					0.00%					33
N			SW-701	$ -	$ -					0.00%					34
N			SW-701	$ -	$ -					0.00%					35
N			SW-701	$ -	$ -					0.00%					36
N			SW-701	$ -	$ -					0.00%					37
N			SW-701	$ -	$ -					0.00%					38
N			SW-701	$ -	$ -					0.00%					39
N			SW-701	$ -	$ -					0.00%					40
N			SW-701	$ -	$ -					0.00%					41
	Special EducationTransportation Monitors			$ -	$ -		$ -		$ -						

Pages 1 Certification Statement

The certification statement of public expenditure will calculate the amount the school district incurred to provide IEP Medicaid services under the SBCH program to Medicaid covered students. The certification statement will automatically populate with the Medicaid applicable cost information reported throughout the cost report as provided by the district.

The form breaks the expenditures out into three categories: Medical Services (Direct Costs), Administrative Services, and Total.

- Direct costs of providing SBCH services include payroll costs and other costs that can be directly charged to SBCH services including costs that are integral to SBCH services. Direct costs do not include room and board. Other direct costs include costs directly attributable to activities performed by the personnel who are approved to deliver SBCH services, including but not limited to travel, purchased services, and materials and supplies. Direct costs are reduced by any federal payments for these costs (adjusted direct costs). Adjusted direct costs are allocated to identify Medicaid-reimbursable costs for SBCH services according to the time study results.

- Indirect costs are calculated using the unrestricted indirect cost rate. Indirect costs are equal to adjusted direct costs multiplied by the unrestricted indirect cost rate. These indirect costs are then added to the adjusted direct costs to determine the total SBCH costs.

- Medicaid allowable cots are identified applying the Medicaid penetration rate to the total direct costs.

The form must be printed on district letterhead and be signed and dated by the Superintendent of Schools in the required areas. Completed forms are then returned to the department using the contact information contained on the bottom of the form.

Original certification forms must be printed on school district letterhead, signed, and submitted to the following address. Faxed or emailed copies **will not** be accepted. Certification forms are required to be completed prior to the submission of the cost report for DSS review.

State of Connecticut-DSS
SBCH Program – 9th Floor
Attn: CON and Rate Setting
55 Farmington Avenue
Hartford, CT 06105-3725

Confirmation of receipt by DSS will be provided by email correspondence.

During the settlement process, statewide time study results for direct service providers are applied to the cost report (specifically Worksheets #2, #2a, #3-404, #4-407, #5-408, and #9-411 to determine the district's Medicaid reimbursable direct costs for the program. Each district's Medicaid penetration rate is then applied to the Medicaid-reimbursable direct costs to determine the Medicaid-allowable direct costs for the program. These costs are then compared to the claimed service throughout the school year (Costs to Claims). If costs exceed claims, the district is owed a settlement payment at 25%. If claims exceed costs, the district owes the program a payment at 25%. Upon completion of the settlement process, a secondary certification statement will be sent to the district for final signature indicating that the certification is for the "finalized cost report".

Certification Statement Form

State of Connecticut Medicaid
School Based Child Health (SBCH) Program
Direct Medical Services and Administrative Activity Annual Cost Report

Certification Statement

Governmental Provider Name and Address:

	0	**National Provider Identifier:**	0
	0	**Reporting Period From:**	7/1/2014
	0	**Reporting Period To:**	6/30/2015

Type of Report:

x	**District Prepared Cost Report**	**Medical Services:**
	Finalized Cost Report	**Administrative Services:**
	Desk Review Date	**Total**

Total Computable Expenditure by Type:

Claimed Expenditures:

This statement is of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid Program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instructions, and guidance issued by the singe state agency and in effect during the year ended 06/30/2015.

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE SCHOOL DISTRICT

I certify that:

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses and services, and the attached worksheets for the reporting period specified above and that to the best of my knowledge and belief theya re true and correct statements prepared from the books and records of the school district in accordance with applicable instructions.
2. The expenditures included in this statement are based on the actual cost of recorded expenditures.
3. The school district is responsible for billing for services for which expenditures have been included in the cost report.
4. The required amount of State and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such State and/or local fundes were used in accordance with all applicable Federal requirements for the non-Federal sharematch of expendtures including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs).
5. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the Department of Social Services (the department) effective for the above reporting period.
6. The school district is responsible for maintaining all documentation supporting the expenditures reported in the cost report. Failure to provide supporting documents during an audit may lead to audit findings and payback/recoupment of federal matching funds received by the school district and payment of any fines or penalty imposed by the pertinent federal and/or state agency.
7. I am the superintendent of the school district and I have made a good faith effort to assure that all information reported is true and accurate.
8. I understand that this infomraiton will be used as a basis for claims for Federal funds and that falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SUPERINTENDENT SIGNATURE _____ DATE _____

SUPERINTENDENT NAME _____ TELEPHONE NUMBER _____

Please print this statement on district letterhead and return by postal mail only to:
State of CT-Department of Social Services
SBCH Program
Attn: CON and Rate Setting
55 Farmington Avenue, 9th Floor
Hartford, CT 06105-3725